THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
800-414-0168
www.mass.gov/dph/boards

## BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

## REQUEST FORM

*Use this form to report a name change, address change and/or request for duplicate license.*
*Mail requests to the address above to the attention of the Board.*
*Check one:*

□ NAME CHANGE □ ADDRESS CHANGE □ DUPLICATE LICENSE

Print/type clearly the information as it **CURRENTLY SHOWS** on your license:

**Name:** _____

**Address**:_____

**City/Town:** _____

**State:**_____

**Board Code:** AP

**Lic. No:** _____

**Lic. Type:** □License □Temporary Practice Cert___

**SSN (*Mandatory*)**:___ _____

**Birth Date:** _____

**Expiration Date**:_____

Print/type clearly the information as you wish it to appear on your **NEW** license.

**Name:**_____

**Address**:_____

**City/Town:**_____

**State:**_____**Zip Code:**_____

**For a name change**, you **MUST** return your current license and submit certified documentation.

**For official use only:**

**Fee:**_____

**Date Received:**_____

**Initial:**_____

If your current license has been **lost or stolen**, please check here. _____

For address changes only, do not return your current license. All addresses are subject to disclosure upon request, pursuant to MGL, Ch.4, Section 7.

Under the penalties of perjury, I declare that the information provided herein is a truthful and complete statement of the information required.

_____
Signature

_____
Telephone Number

_____
Date

**Fees:**

| | |
|---|---|
| **1. Duplicate License** | **$17.00** |
| **2. Name change with new license** | **$27.00** |
| **3. Address changes only** | **no fee** |

**Make check or money order payable to the Commonwealth of MA.**
**DO NOT SEND CASH**